MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

State Employee and Retiree Health and Welfare Benefits Program

Medical Plan Changes

Effective July 1, 2012

A Few Basics First…

- What does in-network mean?
  - Your plan contracts with a group of providers and hospitals who agree to accept a lower payment amount for their services (allowed benefit)
  - These providers agree to not bill the plan's members for charges above the accepted amount
  - These providers submit claims for the plan's members
  - The plan pays the provider directly

- What does out of network mean?
  - Providers who have not contracted with your plan are considered out of network
  - These providers are allowed to bill you for the difference between what the plan pays and what is actually charged for the service
  - These providers may or may not submit claims for you
  - The plan sends payment to you and you pay the provider

A Few Basics First…

- What is coinsurance?
  - It is the cost sharing between you and the plan on certain services
  - 100% coinsurance means the plan pays all of the costs and you pay nothing
  - 80% coinsurance means the plan pays 80% of the costs and you pay 20%
  - It is different for services you receive from in-network providers than for services you receive from out of network providers
- What does out of pocket maximum mean?
  - For services where you pay a share of the coinsurance, a limit is placed on your costs to protect you from a financial hardship
  - This is the limit on what you pay out of your pocket for your share of the coinsurance during the entire plan year
  - Once this is met, you pay no more coinsurance for the rest of the plan year

PPO and POS Only - Coinsurance Changes

- In-Network
  - 100% coinsurance changes to 90% coinsurance
    - inpatient/outpatient hospitalization
    - anesthesia
    - diagnostic x-ray/lab (unless preventive in nature)
    - ambulance services
    - chemotherapy/radiation
    - organ transplants
  - Applies to all services **except** those with a copay
    - office visits (primary care and specialists)
    - physical, occupational and speech therapy
    - urgent care facility
    - emergency room

PPO and POS Only - Coinsurance Changes

- Out of Network
  - 80% of allowed benefit after deductible changes to 70% of allowed benefit after deductible
    - Services not covered out of network remain not covered

PPO and POS Only
In-Network Changes

Through 6/30/12:

- No deductibles
- Plans pay 100% for all in-patient and out-patient hospitalization
- No out of pocket max

Beginning 7/1/12:

- No deductibles
- Plans pay 90% for all in-patient and out-patient hospitalization
- $1,000 out of pocket max per individual/$2,000 per family

PPO and POS Only

Coinsurance Out of Network Changes

Through 6/30/12:

- 80% of allowed benefit after deductible
- $250 deductible per individual/$500 per family
- $3,000 out of pocket max per individual/$6,000 per family

Beginning 7/1/12:

- 70% of allowed benefit after deductible
- $250 deductible per individual/$500 per family
- $3,000 out of pocket max per individual/$6,000 per family

Example A – In-Network

- You have an outpatient surgery claim for $5,000. The plan's allowed amount is $3,000.
- If those services are provided by a physician and facility that are in your plan's network your cost is $300.
  - Plan pays 90% of the allowed amount ($2,700), you pay 10% ($300)
  - 3000 x .90 = 2700
  - 3000 x .10 = 300
- In-network providers cannot bill you for the amount charged that is over the plan's allowed amount
- In-network out of pocket maximum is $1,000 per plan year
  - This is the most you will pay for your share of the coinsurance for the entire plan year
  - Once paid, services are covered in full for the rest of the plan year
    - Copays still apply

Example B – Out of Network

- You have an outpatient surgery claim for $5,000. The plan's allowed amount is $3,000.
- If those services are provided by a physician and facility that are NOT in your plan's network your cost is $3,000.
  - Plan pays 70% of the allowed amount ($2,100), you pay 30% PLUS any amount above the allowed amount until you reach your out of pocket limit of $3,000 ($3,000)
  - 3000 x .70 = 2100
  - 3000 x .30 = 900
  - Amount over allowed amount = 2000 (5000 – 3000)
  - 2000 + 900 = 2900
- The out of network out of pocket maximum per individual is $3000
  - You will never pay more than $3000 in any plan year

PPO, POS and EPO Copay Changes

Through 6/30/12:

- Specialist office visit
  - $25 copay
- Urgent care
  - $20 copay
- Emergency room
  - $50 facility copay PLUS
  - $50 physician copay

Beginning 7/1/12:

- Specialist office visit
  - $30 copay
- Urgent care
  - $30 copay
- Emergency room
  - $75 facility copay PLUS
  - $75 physician copay

PPO, POS and EPO

No Changes to the Following Benefits

- In-network primary care provider office visit copay remains $15

- In-network preventive care still covered at 100% with no copay
  - routine GYN exams/mammograms
  - adult/child physicals
  - immunizations and vaccines